Texas Department of Insurance
Division of Workers' Compensation
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address:

DWC Claim #:
Injured Employee:
Date of Injury:
Employer Name:
Insurance Carrier #:

Respondent Name:
UNIVERSITY OF TEXAS SYSTEM

Carrier's Austin Representative Box
Box Number 46

MFDR Tracking Number:
M4-12-3459-01

MDFR Received Date
JULY 26, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: A position summary was not submitted by the requestor.

Amount in Dispute: $288.34

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "First, the charges in dispute were denied as not medically necessary… Third, the proper venue for medical necessity dispute is provided per Division's Rule 133.308 NOT Medical Fee Dispute Resolution per Rule 133.307.

Response Submitted by: The University of Texas System, PO Box 20041, Houston, TX 77225

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 15, 2010 through July 12, 2011	Out-of-Pocket expenses - Untimely	$113.74	$0.00
August 11, 2011 through April 12, 2012	Out-of-Pocket expenses - Timely	$174.57	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for injured employees to pursue a medical fee dispute.
2. 28 Texas Administrative Code §133.305 sets out the general medical provisions.
3. 28 Texas Administrative Code §133.308 sets out the procedures for medical dispute resolution of medical necessity disputes.
4. 28 Texas Administrative Code §133.270 sets out the procedures for injured employees to submit workers' compensation out-of-pocket expenses to the insurance carrier for reimbursement.
5. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits Explanations of Benefits were not submitted by either party. A letter dated June 13, 2012 from The University of Texas System denied reimbursement of medications as they were not deemed a medical necessity.

Issues

1. Did the requestor meet the requirements for filing a dispute under 28 Texas Administrative Codes §§133.305 and 133.307?
2. Is the requestor entitled to reimbursement?

Findings

1. The requestor filed a dispute with the Medical Fee Dispute Resolution section at the Division on July 26, 2012. The dates of service in dispute range from August 15, 2010 through April 12, 2012. In accordance with 28 Texas Administrative Code §133.307(c)(1)(A) dates of service November 15, 2010 through July 12, 2011 are outside the one-year filing deadline and are not eligible for review.

   According to 28 Texas Administrative Code §133.305(a)(4), a medical fee dispute is a dispute that involves an amount of payment for non-network health care rendered to an injured employee for health care determined to be medically necessary and appropriate for treatment of that employee's compensable injury. 28 Texas Administrative Code §133.305(b) goes on to state that "If a dispute regarding compensability, extent of injury, liability, or medical necessity exists for the same service for which there is a medical fee dispute, the disputes regarding compensability, extent of injury, liability or medical necessity shall be resolved prior to the submission of a medical fee dispute for the same services in accordance with Labor Code §413.031 and 408.021." 28 Texas Administrative Code §133.307(e)(3)(G) requires that if the request contains an unresolved adverse determination of medical necessity, the Division shall notify the parties of the review requirements pursuant to §133.308 of this subchapter (relating to MDR by Independent Review Organizations) and will dismiss the request in accordance with the process outlined in §133.305 of this subchapter (relating to MDR--General). The appropriate dispute process for unresolved issues of medical necessity requires the filing of an Independent Review Organization (IRO) pursuant to 28 Texas Administrative Code §133.308 prior to requesting medical fee dispute resolution. No documentation was submitted to support that the issue(s) of medical necessity have been resolved as of the undersigned date.
2. The requestor has failed to support that dates of service August 11, 2011 through April 12, 2012 are eligible for medical fee dispute resolution pursuant to 28 Texas Administrative Code §133.307

Conclusion

For the reasons stated above, the requestor has failed to establish that the respondent's denial of payment reasons concerning medical necessity have been resolved through the required dispute resolution process as set forth in Texas Labor Code Chapter 413 prior to the submission of a medical fee

dispute for the same services. Therefore, medical fee dispute resolution staff has no authority to consider and/or order any payment in this medical fee dispute. As a result, no amount is ordered.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	October 5, 2012 Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.